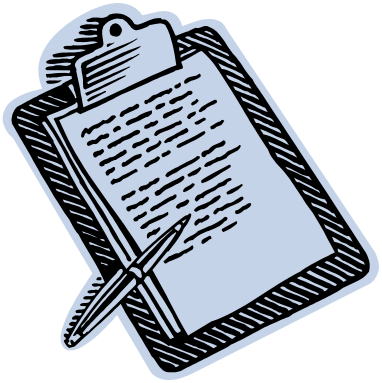
OKLAHOMA
EMERGENCY MEDICAL SERVICES

Prehospital Care Report
Instruction Manual



August 2002

PREHOSPITAL CARE REPORT INSTRUCTION MANUAL

PREFACE

Historically speaking, prehospital data collection instruments in use in the State of Oklahoma were developed based on extensive research of local, state, and national EMS reporting form needs and experiences. Through the experience of trial and error, and as a result the efforts of consensus work groups, this revised report form is designed to provide information regarding prehospital care activities for all of Oklahoma EMS provider agencies, EMS coordinators, and local medical directors. It should, with experience, prove easier and faster to complete, while providing information essential to the local and state EMS systems. The form is computer scannable so that critical information may be efficiently entered into a central file for analysis by your local EMS agency.

For example:

- EMS provider agencies will have accurate information regarding frequency and peak periods of calls, call types, response times, and general unit performance.
- Quality Assurance coordinators will be able to obtain a summary of field experience for their personnel over a certain period of time. Such a summary will include case types, scene times, procedures performed, success ratios, categories of drugs administered, and patient outcomes. This information may be used for evaluation, recertification purposes, and for continuing education planning.
- Medical directors will be able to critically evaluate the effectiveness of various treatment protocols and medication categories for use in future EMS planning and education.
- Finally, regulatory agencies are in need of data illustrating the effectiveness of all the elements of the EMS system to ensure continued financial support of EMS and to aid in EMS planning.

310:641-3-160 Ambulance service and first response agency files

(a) Each licensed ambulance service and first response agency shall maintain files about the operation, maintenance, and such other required documents, at the business office. These files shall be available for review by the Department, during normal work hours. Files which shall be maintained include the following:

(1) Copies of all run reports shall be retained for three (3) years, including copies of scannable run sheets and its narrative and;

(A) A copy of the run report shall be left with the receiving hospital at the time a patient(s) is (are) accepted at the hospital.

(B) All run reports shall contain administrative, legal, medical, community health, and evaluation information required by the Department.

(C) All run reports and their narrative(s) shall be considered confidential….

Thank you for your cooperation.

Emergency Medical Services Division
Oklahoma State Department of Health
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Oklahoma City, Oklahoma
73117-1299

(405) 271-4027

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GENERAL INSTRUCTIONS

MARKING THE FORM

The Prehospital Care Report is scanned into a computer database by means of a technologically advanced infrared optical mark reader (scanner). This reader will detect ink (both blue and black), as well as pencil.

Since the scanner operates in the infrared spectrum, it cannot detect red marks. Therefore, **PLEASE DO NOT USE RED INK OR RED PENCIL ON THIS FORM.** Errors can be erased or removed with correction fluid.

The complete Patient Care Report Form is 11" tall and 17" wide. For ease in carrying the form on clipboards and in notebooks, the form may be folded so that it is the size of the paper in this Manual, 8.5" x 11". Remember that these are self-carbon forms, and if your form is folded, or on top of another, the pressure you apply with your pen will translate through to the next form or layers of forms. To keep from marking on the second page, place the entire form out flat so that both halves are visible at the same time. When completed, the form may be separated down the center of this fold for local administrative purposes. Avoid stapling, folding or tearing the form in any other manner.

When writing your narrative, and when writing in sections marked "Chief Complaint", "Current Medications" and "Allergies", please print as legibly as possible. This information is transcribed manually and should be as legible as possible.

Please take note that not every field, or section, of this form may apply to every call. If a field does not apply to that call, **leave that field blank.** Inappropriate fields do not need to be marked "N/A", and doing so may cover other marking positions (bubbles) that you wish to leave blank.

WHERE TO FILE COPIES OF THE FORM

Destinations for each copy of the form are designated at the bottom of each page. The original of the entire report form **must be** kept at the service; the second page **must be** turned in to the Oklahoma EMS Division office where the information will be scanned.

ESSENTIAL FIELDS OF THE FORM

There are nine fields that are keys to the Patient Care Report form. If these key fields are not completed, the form(s) will be returned to you for correction. These critical fields are: **Report Number, Incident Date, Call Received, Enroute, Run Type, Response Mode, Response Outcome, Called by, and CrewMember #1.**

See the section of this manual, "Double-Checking Your Form", to prevent mistakes in marking your report form.

COMPLETE FORMS

While filling out the form, please make sure that the appropriate marks are filled in completely. This ensures that the scanner will read the best mark. It is in your best interest, both medically and legally, to complete this form to the fullest extent possible every time.

ERRORS, VOIDING FORMS

If the form is grossly incorrect, just mark the form "VOID", fill out another form, and submit the voided form according to your local policy. These forms are not numbered and accounted for, but may contain confidential patient information not to be disposed of haphazardly. Remember that white correction fluid can be used to correct minor errors. If you use correction fluid, be certain to make the necessary corrections on all three copies of the patient care report form.

ATTACHMENTS

NO ATTACHMENTS – Do not send attachments to the Department. We do not need extra medications, EKG strips, or narrative.

FURTHER ASSISTANCE

All other questions regarding the completion and distribution of the forms should be directed to the Quality Assurance Coordinator of your EMS agency, or to the Oklahoma EMS Division.

NOTES

INCIDENT AND PATIENT INFORMATION

INCIDENT LOCATION

The location of the incident is entered, one letter or number per block, as complete as possible, in the form of street address or directions.

1	2	3	4		W		M	A	I	N		A	P	T		3	B						

4		M	I		E		O	F		U	S		6	9		O	N		6	9	A		

It is recognized that local providers have a tendency to abbreviate common locations within their response areas; i.e., Jones Nursing Home abbreviated to JNH, or Delaware County Medical Center abbreviated to DCMC. There is also the tendency for local providers to list common landmarks, such as Jackson's Corner or the Green Country Store. While this works well for local documentation, it is extremely burdensome for regulatory agencies and consultants who study EMS systems and are not familiar with local abbreviations and landmarks. It is important to provide complete and accurate incident location information.

INCIDENT ZIP CODE

This 5-digit postal ZIP code is important for mileage reimbursement purposes. It also further identifies the incident location. Note that this is the ZIP code for the actual location of the incident, or where the patient was transported from, not the ZIP code of the patient's address.

REPORT NUMBER

The Report Number (top right of page) is to consist of the 3-digit agency license number and then the agency's numbering system. For example, the first run reported from Cimarron County EMS (license number 001) would look like this:

0	0	1	0	0	0	0	0	1	0

It is also important that each patient contact be documented on a separate report form. Each responding vehicle should be assigned its own run number, even if responding to the same incident. It is likely that the agency would contact several patients on the same EMS response. Each patient would be reported separately and would then have an individual report number. Use the last block to list the patient number (1 through 9, use "0" if no patient contacted).

Patients numbers one and two of incident number 127 are documented as follows:

0	0	1	0	0	0	1	2	7	1

0	0	1	0	0	0	1	2	7	2

INCIDENT DATE

Mark one digit per space for the month, date, and complete year of the actual date that you received the call for service. For example, if you received the request for service at 2357 hours of July 27, 2001, and your agency responded to the call at 0002 hours of July 28, 2001, you would enter July 27, 2001.

0	7	/	2	7	/	2	0	0	1

TELEPHONE NUMBER

This is the telephone number from which the request for emergency medical service was made. It may be the telephone number of the patient's residence, or it may be a pay phone or cellular phone number from which the 911 call was placed. This information is frequently available from the 911 communication center. Include the area code, whether it is different from your own or not.

GLOBAL POSITIONING (GPS) LATITUDE / LONGITUDE

If your emergency vehicle is equipped with Global Positioning Satellite location equipment, include the GPS grid coordinates for the actual emergency location in this space. If you do not have this capability, leave this field blank. With this information, the EMS Division may be able to assist local agencies in distribution of resources.

Global Positioning (GPS) - Latitude | Longitude

							–								

PATIENT NAME

Completion of this field is mandatory if you contacted a patient.
Print one letter per space for as much of the patient's last name, first name, and middle initial as will fit. If either name will not fit into the spaces provided, as with some hyphenated last names, include the complete name on the top line of the narrative section. If no patient was found, leave this field blank.

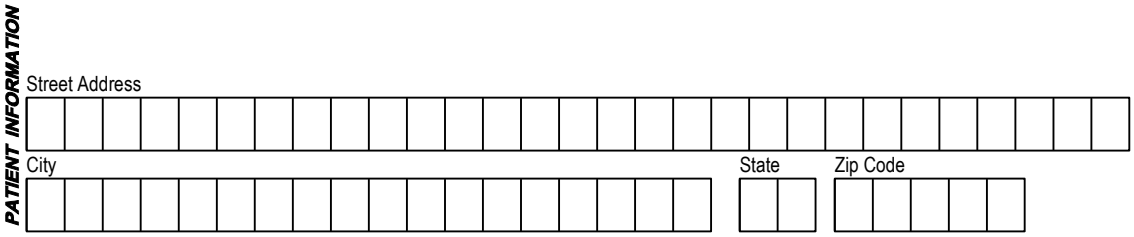
ETHNIC ORIGIN, GENDER

Mark the appropriate bubble to designate the ethnic origin of the patient. If patient's ethnic origin is not listed among the choices, mark "Other." Mark "Unknown" if the patient's ethnic origin cannot be determined. Mark either bubble to identify the patient as male or female.

Ethnic Origin		Gender
○ Asian	○ White	○ Male
○ Black	○ Other	○ Female
○ Hispanic	○ Unknown	
○ Nat Amer		

STREET ADDRESS, CITY, STATE, ZIP CODE

Print one digit or letter per space to indicate the address of the patient's residence. This may be an actual street address, or a post office box. It may also be a rural route and box number. Be reminded that a patient contacted at a residential address may not be at his/her own residence.



SOCIAL SECURITY NUMBER

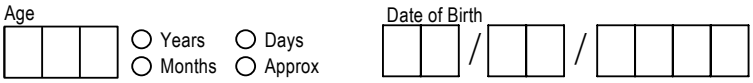
This piece of information is important in patient identification. Many patients may have the same or similar names, but are further identified by their social security number. Print one digit per space.

AGE / DATE OF BIRTH

Completion of this field is mandatory if you contacted a patient.

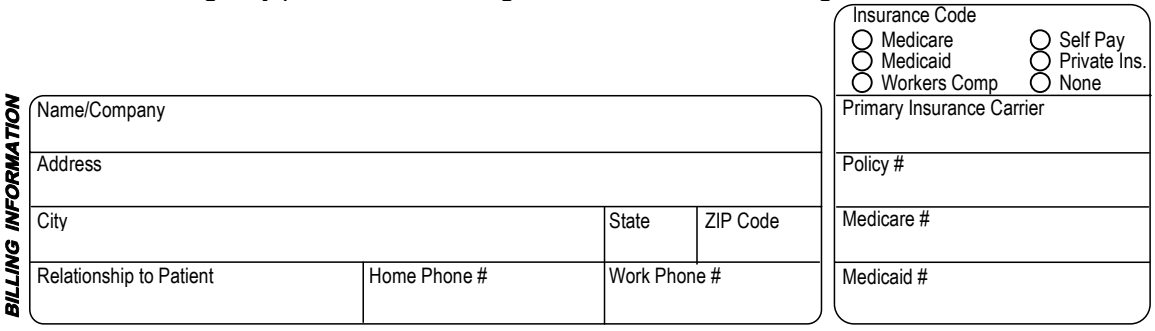
If you are recording the age of an infant, indicate the patient's age in months or days as appropriate. If a patient's age is not known, then a close approximation is allowable. Simply designate that the number is an approximation by marking the bubble next to "Approx". Print one digit per space for the patient's age.

Note: If your patient is 14 years of age or less, you must complete the Pediatric Trauma Score found at the lower right-hand corner of the form, regardless of whether the patient was involved in a trauma-related incident.



BILLING INFORMATION

These fields are provided to assist your agency's billing clerks. Follow your local agency policies in obtaining insurance and other billing information.



CHIEF COMPLAINT

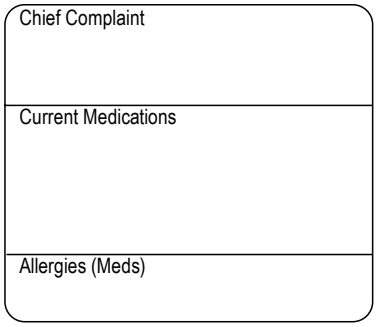
The Chief Complaint is based upon your subjective assessment of the patient. The patient's chief complaint may not necessarily be the reason for the call. What does the patient tell you is wrong with him/her?

CURRENT MEDICATIONS, ALLERGIES

This space is provided for the EMT to list the patient's current medications. List as many as will fit in the space provided. You may wish to list additional medications in the Medical History space or attach a complete list after your arrival at the medical facility.

It is especially important to list the patient's allergy to specific medications in the space provided. You may need to list additional allergies in the Medical History space, if necessary, or attach a complete list after your arrival at the medical facility.

In your documentation of the patient's medications and allergies, it is important to make certain the spelling of medications is correct, as well as dosage amounts, frequency and routes of administration.



NARRATIVE REPORT

NARRATIVE / ASSESSMENT

All contacts of any sort with patients should be documented in the narrative field. It is important to adopt a consistent format in writing your narrative report. The **CHART** format is a good one to follow;

Chief complaint,
History of the incident,
Assessment of the patient,
t**R**eatment of the patient, and
Transportation for further care.

Another good format to adopt is the **SOAP** method of reporting;

Subjective (that is what the patient tells you),
Objective (what you see, hear, feel, smell),
Assessment of the patient, and your
Plan for treating the patient.

Yet another method of documenting your response, particularly when no patient is contacted, as in a sporting event or standby for hazardous materials, fire or police action, is to use the **5 W's**, borrowed from journalists. Write a short paragraph containing the following:

Who?
What?
When?
Where?
Why?

Whatever method you use for writing your narrative report, make certain that you are consistent in including all of the necessary elements. Write as if someone who has never read an EMS report, such as attorney will be reading it. Neatness and correct spelling should be considered as important as the actual information contained in the report. Avoid uncommon abbreviations. Make certain medication names and dosages are transcribed correctly. Quality Assurance Managers, Investigators, and Attorneys all like to be able to read reports without seeking translation. If a report is sloppily written, laden with misspelled words, or is otherwise illegible, the reader may rightfully be concerned about the quality of assessment and treatment given the patient.

Narrative/Assessment

Report given to:_____ Narrative page 1 of _____ pages

NECESSITY FOR SERVICE

Recent changes in federal and other third-party reimbursement programs have made it necessary for EMS providers to document the reason(s) a patient could not have been transported by any other means than by ambulance vehicle. EMS providers are also required to document what medical conditions require certain medical assessments and interventions. The quality of the EMT's documentation practices has a direct bearing on the amount of reimbursement the provider receives.

Upon Arrival, Patient found in:

- ❍ Ambulating — includes walking at the scene
- ❍ Geri/Cardiac chair
- ❍ Recliner
- ❍ Wheelchair
- ❍ Bed
- ❍ Gurney/Exam table — includes emergency room bed
- ❍ Other_____ — includes car, ditch, water, burning house, sofa, lying on floor, etc.

Was Stretcher Necessary?

- ❍ Unable to sit upright
- ❍ Unable to balance in sitting position
- ❍ Unconscious/Shock
- ❍ Req. Physical restraints
- ❍ Severe hemorrhage
- ❍ Bed confined
  - ☐ Fetal position ☐ Contractures ☐ Paralyzed
- ❍ MI
- ❍ Unset or poss. fracture
- ❍ Acute stroke
- ❍ MVC
- ❍ Other_____

Patient Moved to Stretcher via:

How was the patient moved to the cot/stretcher? "Total lift" includes spine board and carries.

- ❍ Total lift
- ❍ Draw sheet
- ❍ Other_____

Did Patient:

- ❍ Vomit
- ❍ Complain of nausea
- ❍ Complain of pain

Was Patient:

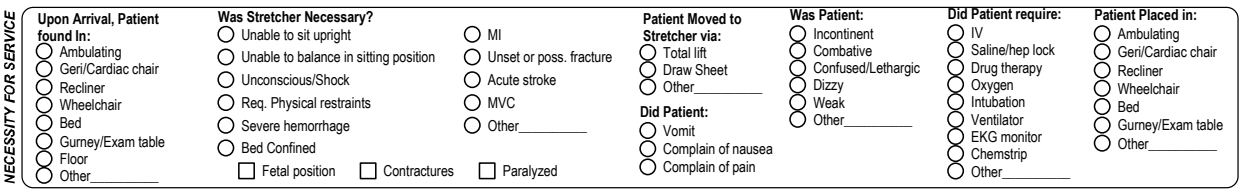
- ❍ Incontinent
- ❍ Combative
- ❍ Confused/Lethargic
- ❍ Dizzy
- ❍ Weak
- ❍ Other_____

Did Patient Require:

- ❍ IV
- ❍ Saline/Hep lock
- ❍ Drug therapy
- ❍ Oxygen
- ❍ Intubation
- ❍ Ventilator
- ❍ EKG monitor
- ❍ Chemstrip
- ❍ Other_____

Patient Placed in:

- ❍ Ambulating
- ❍ Ger/Cardiac chair
- ❍ Recliner
- ❍ Wheelchair
- ❍ Bed
- ❍ Gurney/Exam table
- ❍ Other_____



VITAL SIGNS, TREATMENT, OTHER DOCUMENTATION

VITAL SIGNS

This field is for documenting your patient's initial and subsequent vital signs (pulse, respiratory rate, blood pressure, level of consciousness, oxygen saturation, and EKG interpretation). Remember that no set of vital signs is complete without documenting the time those vital signs were measured. There are five lines for documenting five sets of vital signs. Remember that no live patient's condition can be declared to be stable unless two or more complete sets of vital signs are documented.

Document the measured pulse in rate (beats per minute), rhythm (regular or irregular), and quality (weak, thready, bounding, etc.).

Document the measured respirations in rate (breaths per minute), and quality (shallow, labored).

Document the blood pressure as systolic / diastolic. ***Avoid palpated pressures: they are inaccurate.*** If you were unable to measure the blood pressure, indicate the reason in your narrative report; i.e., combative, burns, fractures, etc.

Document level of consciousness using the **AVPU** method. The patient is **A**lert, responsive to **V**erbal stimulus, responsive to **P**ainful stimulus, or is **U**nresponsive. Any patient's level of consciousness that deviates from being fully alert and oriented to person, place, time, and event, should be fully described in the narrative portion of the report. Document the Glasgow Coma Scale measurement / indicator as well.

When you document the patient's pulse oxygenation saturation indicate whether the measurement is on room air (RA) or is with oxygen administration.

If your standard of care provides that you may interpret electrocardiogram, you may indicate your interpretation in the space provided. Abbreviations are appropriate; i.e. Ventricular Tachycardia = V-Tach. Further elaborations should be included in the narrative.

TREATMENT / RESPONSE

There are lines for you to record your treatment and the patient's response to that treatment, and the time you administered or began that treatment. There is space for up to ten interventions. Interventions that should be documented should include, but not be limited to, oxygenation, intravenous access, securing airway, defibrillation, drug administration, splinting and immobilization, bleeding control, bandaging, etc. The patient's response to your intervention, if any, should also be noted. For example, O_2 10 LPM = decreased dyspnea. Or another example might be, 2 mg Valium IV = reduced anxiety.

TIME	PULSE	RESP	B/P	LOC	O2 SAT%	EKG	TIME	TREATMENT / RESPONSE	TIME	TREATMENT / RESPONSE
			/							
			/							
			/							
			/							
			/							

CREW IDENTIFICATION

This field, labeled “Crew #1”, “Crew #2”, and “Crew #3”, is the space for the crewmembers’ signatures. Beneath the signature block are bubbles to be filled in to indicate the license level of the crewmember.

B	EMT-Basic
I	EMT-Intermediate
AC	EMT-Advanced Cardiac
P	EMT-Paramedic
HP	Health Provider; i.e., Resp. Therapist, Reg. Nurse, Physician
Oth	Other individual; i.e., firefighter, police officer, family member
1stR	First Responder
Stdnt	Student; First Responder student, EMT or other level student

RESEARCH CODE

This field allows for customized reporting of data not already being collected by your local agency. It is to be left blank unless you are instructed to use it by your local administrator.

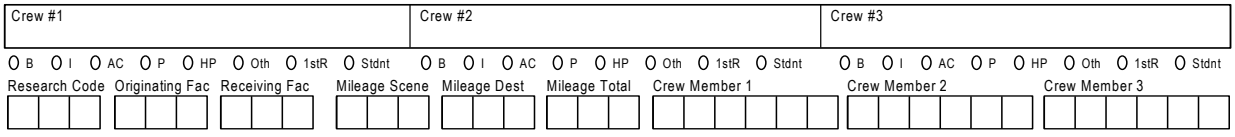
ORIGINATING / RECEIVING FACILITIES

All hospitals in the State of Oklahoma, and those hospitals outside the state that are frequented by Oklahoma EMS agencies, have been issued a three-digit EMS Code number. These EMS Code numbers assigned to Oklahoma hospitals are the same as the radio encoder numbers for use on the HEAR radio frequency, 155.340 mHz. A list of these hospital EMS Code and encoder numbers is found in the Oklahoma EMS Registry, published annually by the Oklahoma State Department of Health.

When your patient transport originates at a hospital, enter the appropriate EMS Code number in this field. When your patient’s destination is a hospital, enter the appropriate EMS Code in this field. A residence or nursing facility will not have an EMS Code number. Therefore leave this field blank.

MILEAGE

Record your ambulance vehicle’s mileage for this call. **Mileage Scene** is the number of miles from your station, or from the location from which you responded to the scene. **Mileage Dest** is the number of miles from the scene to your destination. **Mileage Total** is your total mileage for the entire trip.



CREW MEMBER IDENTIFICATION

While it is recognized that other EMS personnel from other agencies may also participate in the care of the patient, this field is strictly for use by the personnel of your vehicle. Other participants (additional personnel from your own or other agencies) should be mentioned in your narrative report. Place your Oklahoma Emergency Medical Technician license number in this field. Other licensed personnel, Registered Nurses and Physicians, should indicate their license level and then leave the spaces for license number blank.

RESPONSE INFORMATION

RESPONSE TIMES

The following fields on the form require a time of day entered in **MILITARY TIME FORMAT.**

	Use Military Time			
Call Received				
Enroute				
Arrive Scene				
Depart Scene				
Arrive Dest.				
Return Service				

When entering times in military format in these fields, remember that a blank space in any field does not interpret as a zero. 1:00 P.M. must be marked as "1300", not as "13" followed by two blank squares.
NOTE: To mark a time as MIDNIGHT, fill in "2400". 12:01 A.M. should be marked as "0001".

CALL RECEIVED

The time that the initial call for assistance was received.
Completion of this field is mandatory.

ENROUTE

The time your vehicle began responding to the scene.
Completion of this field is mandatory.

ARRIVE SCENE

The time your vehicle arrived at the scene of the incident. **LEAVE BLANK on cancelled calls**, as your vehicle did not arrive at the scene. Be certain to mark "Canceled" in the Response Outcome field when response is terminated prior to arrival at the scene.

DEPART SCENE

The time your vehicle left the scene of the incident. **LEAVE BLANK on cancelled calls. See "FROM SCENE" for Response Mode and Outcome.**

ARRIVE DEST.

The time your vehicle arrived at the hospital, medical facility, or other destination.
LEAVE BLANK on cancelled calls.

RETURN TO SERVICE

The time your vehicle was back in service, i.e., after re-supplying and cleaning your vehicle, or when the vehicle is available for service following a cancellation or refusal. This time should be equal to or later than the time marked for when the vehicle DEPARTed SCENE and/or ARRIVE DESTination. **Completion of this field is mandatory.**

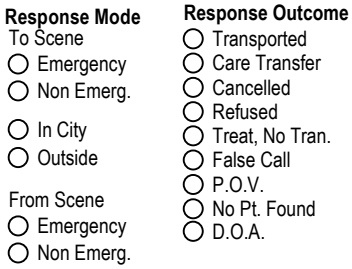
RESPONSE MODE

TO SCENE

Designate in which mode you responded **TO** the scene **AND** if the location is IN CITY or OUTSIDE. **Completion of this field is mandatory.**

FROM SCENE

Designate in which mode you departed **FROM** the scene. If you listed a time in DEPART SCENE, then this field must be marked.



RESPONSE OUTCOME

This field is to record the outcome of the call. **THIS FIELD MUST BE COMPLETED, WITH ONLY ONE MARK, FOR EVERY CALL.**

Transported – Your vehicle transported the patient.

Care Transfer – Care of the patient was transferred to **ANOTHER** transporting agency. For example, your BLS ambulance transported the patient to a rendezvous point, and then transferred care to an ALS ambulance service.

Cancelled – Your vehicle was cancelled by the communications center prior to your arrival at the scene.

Refused – Patient signed a refusal statement refusing treatment and transport. A refusal statement is found at the bottom of the Prehospital Patient Care Report Form.

Treat/No Transport – No transport; patient was assessed and treated at scene but either did not require or refused transport, and was released after signing refusal statement. Mark this field if the patient refused transport and refused to sign the refusal statement.

False Call – Upon arrival at the scene, no cause for treatment or transport was found. This could have been a 911 hang-up or otherwise accidental or malicious call.

P.O.V. – A privately owned vehicle rendered transport.

No Pt. Found – Upon arrival at the scene, no patient was found.

Standby – Response was for purposes of availability in case of a medical/traumatic emergency, such as sporting events, fires, or police action.

DOA – No treatment rendered as patient was dead upon the vehicle's arrival at the scene. If the EMS transports this deceased person, mark that you TRANSPORTED the patient, and indicate the patient had no pulse or respiration in the VITAL SIGNS fields.

TYPE OF CALL

Please mark the one choice that designates the general nature of the call.
Prehospital (anything not a standby or inter-facility transfer),
Standby for sporting, community events, fire, or police action.
Inter-facility Transfer, between hospitals or other health care facilities.
Completion of this field is mandatory.

Prehospital

Medical Illness is any chief complaint that is not traumatic in nature.
Trauma is any chief complaint originating from a mechanism of injury.

Transfer Type

Admission Transfer is a patient transferred into a hospital to be admitted. This can be from a residence to a nursing facility, or from a nursing facility to another, or a patient you know will be directly admitted.

Discharge (Hosp.) is when a patient is discharged from a hospital to return to a residence or extended care facility.

Inter-facility (Hosp.) is when a patient is transferred from one hospital to another for more definitive treatment, or for step-down care.

Medical Control

Did the EMTs perform skills according to a Protocol (standing order) or with On-line medical direction? Did the patient possess a "Do Not Resuscitate" order?

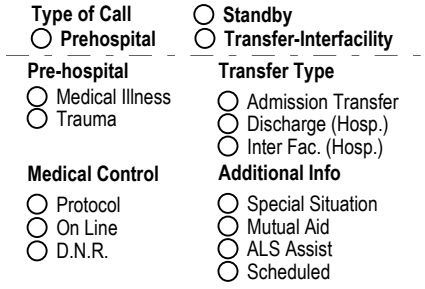
Additional Info

Special Situation may include a standby for police action or major structure fire. It may include a sporting or other community event standby.

Mutual Aid is when your vehicle responds to assist another EMS agency, or responds in lieu of another EMS agency.

ALS Assist is when your ALS vehicle is called upon to assist a BLS unit.

Scheduled is for any scheduled transfer or standby. This helps further identify your call as not being an emergency situation.



INCIDENT LOCATION

Mark only one selection in this field if "ARRIVE SCENE" is marked. Use this field to document the location of the call. If you are unsure or nothing seems to apply, then mark "**Other**".

Residence – designated as a place of abode, not necessarily the patient's own residence. If you have a call to a residence, mark this selection.

Highway – any publicly traveled highway, road, or street with a speed limit of greater than or equal to 55 mph. Included in this designation are state and federal highways, turnpikes, freeways, etc.

Other Traffic Way – any roadway with speed limits generally less than 55 mph. Included are city streets, county roads, and private parking lots.

Water – any area that serves as a route for water (streams, rivers, flood run-offs, recreational lakes, etc.) If dry, do not mark this spot.

Office/Business – any place that exists for the purpose of conducting business.

Education Facility – any educational facility, elementary through college, or any area designed specifically for children to play.

Farm/Ranch – any area that has as its purpose the raising of crops or animals.

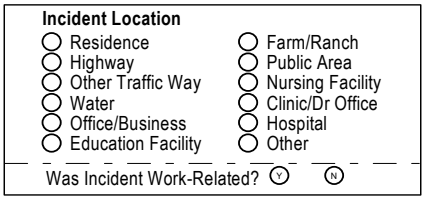
Public Area – any place frequented by the general public (parks, malls, banks, churches, etc.). Includes specific locations recognized for recreational activities (ballparks, ski areas).

Nursing Facility – any facility that has as its purpose the provision of long-term, residential care in addition to some level of non-skilled or skilled medical care (nursing homes, convalescent centers, hospices, residences of disabled individuals, in-patient substance abuse centers, etc.).

Clinic/Dr Office – any medical facility that is utilized primarily for the non-emergent diagnosis and/or short-term treatment of patients.

Hospital – a licensed facility that has as its primary purpose the delivery of medical care (trauma centers, hospitals, specialty centers, mental health hospitals, observation evaluation centers, minor emergency centers).

Other – any location that does not fit one of the above descriptions.



Was the incident work-related?

This field helps establish need for work-place safety education and enforcement, and helps verify worker compensation claims.

CALLED BY:

Indicate who placed the call for EMS assistance. This information can be obtained from the communications center. Also indicate whether 911 was used in placing the call.

Called By

- ○ Patient/Family
- ○ Bystander
- ○ Fire
- ○ Police
- ○ Nursing Fac
- ○ Acute Care Fac

Used 911

- ○ Yes
- ○ No

Assistance

	None	By-stander	1st Resp	Fire	Police
First Aid	○	○	○	○	○
AED		○	○	○	○
BLS		○	○	○	○
ALS		○	○	○	○

ASSISTANCE

This field is used to document any aid given prior to your vehicle's arrival. Multiple marks may be made to clarify an incident. "None" should be marked if no prior aid was rendered.

SUSPECTED MEDICAL ILLNESS

Use this field to record the one major type of medical problem associated with this patient. That is, the Primary illness is the patient's Chief Complaint. You may then mark as many Secondary illness or symptoms that the patient may have. Your choices should take into account the patient's medical history and your findings through the initial assessment.

MARK ONLY ONE PRIMARY CHOICE

NOTE: If the TYPE OF CALL denotes a "Medical" call, then you must mark one Primary response in this field. You may indicate a medical problem when the TYPE OF CALL denotes a "Trauma" call, but be careful. For example, if the patient's chest pain was a result of the trauma, do not mark the "Chest Pain" bubble in this field. If however, your patient tells you he had chest pain prior to his auto striking the tree, you may mark "Cardiac Symptoms" in this field.

Suspected Medical Illness

Primary	Secondary
Mark 1	*Mark All that apply*
○	○ Abdominal Pain
○	○ Airway Obstruction
○	○ Allergic Reaction
○	○ Behavioral
○	○ Breathing Difficulty
○	○ Cardiac Arrest
○	○ Cardiac Symptoms
○	○ Chest Pain
○	○ CVA
○	○ Dehydration
○	○ Dizziness
○	○ Gynecological
○	○ Hypertension
○	○ Hypo/Hyperglycemia
○	○ Hypo/Hyperthermia
○	○ Nausea/Vomiting
○	○ Obstetrical
○	○ Pain
○	○ Paralysis
○	○ Poisoning/Ingestion
○	○ Respiratory Arrest
○	○ Seizure
○	○ Shock
○	○ Unconscious
○	○ Weakness
○	○ Other

SAMPLE 1- *you are called to a residence for a possible CVA. Primary Illness is CVA. Secondary might include Hypertension, Nausea, and Breathing Difficulty.*

SAMPLE 2 - *You are called to report of Motor-Vehicle Collision. Upon assessment, your patient complains that he had Chest Pain prior to the collision (he was driving himself to the clinic). He also sustained traumatic soft-open injury to the head and face. Document Primary Illness as Chest Pain. Document the injuries in the Injury Site/Type Field.*

BLS TREATMENT

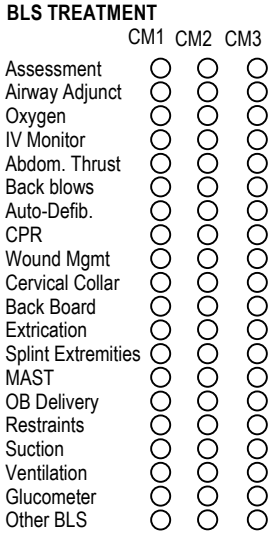
This field contains a list of approved procedures for the EMT-Basic and First Responder.

NOTE: Mark as many responses as necessary to indicate who performed the procedures. Both BLS and ALS personnel can perform these procedures, and multiple crewmembers may perform the same skill. For example, it may require more than one crewmember to perform CPR.

Mark only those procedures performed by your agency's personnel.

The **CM1, CM2,** and **CM3** designators refer to Crewmember 1, Crewmember 2, and Crewmember 3, as identified previously.

NOTE: *It is important to perform an Assessment on ALL patients!*



SAMPLE BLS TREATMENT
CM1 Performs Assessment, Airway, Clear, Oxygen. CM2 Performs Cerv. Collar, Backboard, Extrication. CM3 assists with Extrication.

ALS TREATMENT

This field should only be completed by EMT-Intermediate, EMS-Advanced Cardiac, or EMT-Paramedic, as it contains a list of approved procedures for ALS Personnel. Mark as many responses as necessary to indicate who performed the procedures. Crewmembers can perform the same skill, such as when two paramedics each initiate intravenous access so the patient has two IV lines established.

If an ALS procedure is performed that is not among the choices listed, mark "Other" and document the procedure in your narrative. Remember if you perform ALS procedures, do not forget to include the BLS procedures you performed. Mark only those procedures performed by your agency's personnel. For

example, if you called for a helicopter and the flight nurse performed a needle thoracotomy, you would not list that procedure, as you did not perform that procedure.

ALS TREATMENT

	CM1	CM2	CM3
Assessment	○	○	○
Blood Draw	○	○	○
IV-Central	○	○	○
IV-Ext. Jugular	○	○	○
IV-Intraosseous	○	○	○
IV-Peripheral	○	○	○
Cardiac Monitor	○	○	○
Cardioversion	○	○	○
Manual Defib.	○	○	○
Pacing	○	○	○
PTL	○	○	○
Nasal Intub.	○	○	○
Oral Intub.	○	○	○
Drug Admin.	○	○	○
Cricothyrotomy	○	○	○
Needle Thorac.	○	○	○
Glucometer	○	○	○
12 Lead	○	○	○
Other ALS	○	○	○

SAMPLE ALS TREATMENT

CM1 Assessment, Blood Draw, Peripheral IV *CM2 performs Cardiac Monitor, Drug Admin.*

MEDICAL HISTORY

Use this field to document any pertinent medical history. **Mark all selections that apply.** If the patient has no prior medical history, mark "None". If patient's medical history has no bearing on the current incident, mark "Non-Pertinent". For example, you are called to treat a patient with a sprained ankle and she indicates she had throat cancer in 1987. You may also wish to elaborate on the medical history in the blank space provided beneath this field.

Medical History

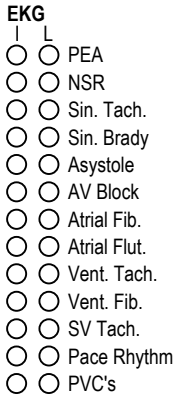
- ○ Allergies
- ○ Asthma
- ○ Behavioral
- ○ Cancer
- ○ Cardiac
- ○ CHF
- ○ COPD
- ○ CVA
- ○ Diabetes
- ○ Drug/ETOH
- ○ Emphysema
- ○ HTN
- ○ Com Disease
- ○ Recent Surgery
- ○ Renal Failure
- ○ Seizures
- ○ Non-Pertinent
- ○ Other
- ○ None

Medical History

EKG

When **Cardiac Monitor** is marked in the ALS Treatment field, **the appropriate rhythm must be marked in this field.** Be sure you mark the **I**nitial and **L**ast Rhythms, especially when Manual Defibrillation or Cardioversion are marked under ALS Treatment. Possible rhythms are as follows:

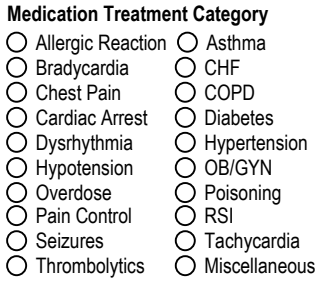
- PEA = Pulseless Electrical Activity
- NSR = Normal Sinus Rhythm
- Sin. Tach. = Sinus Tachycardia
- Sin. Brady = Sinus Bradycardia
- Asystole
- AV Block = all types atrioventricular heart blocks
- Atrial Fib. = Atrial Fibrillation
- Atrial Flut. = Atrial Flutter
- Vent. Tach. = Ventricular Tachycardia
- SV Tach. = Supraventricular Tachycardia
- Pace Rhythm
- PVCs = Premature Ventricular Complexes



SAMPLE EKG – *Patient was found in Ventricular Fibrillation and was converted to Normal Sinus Rhythm.*

MEDICAL TREATMENT CATEGORY

Use this field to record the medications you administered according to medical treatment category, or protocol by which you administered the medication. Mark only those treatment categories for the medications you administered. Do not include any prescription medicines the patient may have taken prior to your arrival. For example, if you administered Atropine for a bradycardic rhythm, you would mark Bradycardia. However, if you administered Atropine for an organophosphate poisoning, you would mark Poisoning.



CARDIAC ARREST

This field is used to gather information on cardiac arrest patients.

Time of Arrest

To the best of your knowledge, based on witness and dispatch information, what time did cardiac arrest occur.

Time CPR

To the best of your knowledge, based on witness and dispatch information, what time was CPR initiated prior to your arrival? If CPR was not in progress prior to your arrival, what time did you initiate CPR?

Time BLS

What time did First Responders or BLS ambulance service arrive?

Time ALS

What time did ALS ambulance arrive at scene or intercept?

Time Defib

What time was the first defibrillation administered, whether by First Responders or by BLS or ALS ambulance crew?

Witnessed Arrest?

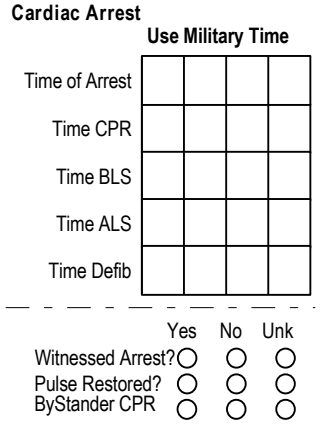
Mark one answer in this field.

Pulse Restored?

Mark one answer in this field. If, following CPR, the patient regains a pulse, mark Yes.

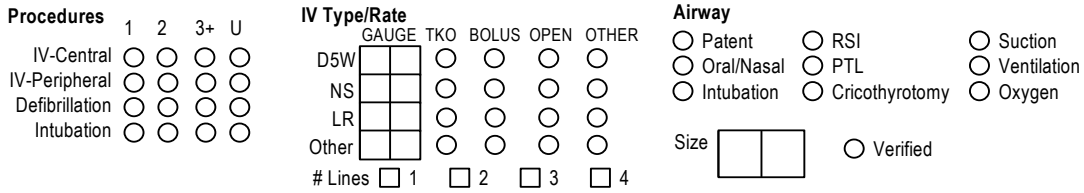
Bystander CPR?

Mark one answer in this field.



PROCEDURES

This field is used to document the **TOTAL** number of attempts (by all personnel) to perform the various procedures listed. Document the number of attempts and whether you were unable to successfully perform the attempted procedure (U). For purposes of completing this field, external jugular venous access is considered to be IV-Central. ***It is important to be completely honest on this one!***



IV TYPE / RATE

Use this field to indicate the type of IV solution administered, the rate of administration, the number of lines used, and the size (gauge) of catheter used. The categories for rate of administration are:

TKO	To Keep Open
BOLUS	A defined rate of administration; 250 or 500 cc.
OPEN	Running the IV open all the way. If a specific rate is ordered, then be sure to record the rate amount in the narrative report.
OTHER	Any other rate.

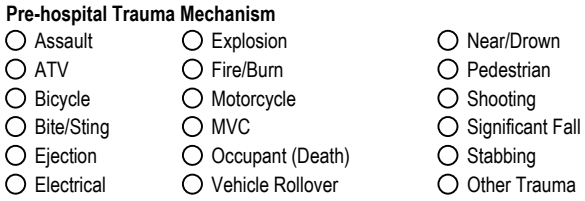
Indicate, in the boxes, the gauge size of needle/catheter used to initiate the IV. Denote the total number of lines started on the patient, including Saline or Heparin locks. Do not include piggybacks.

AIRWAY

Use this field to indicate the status of the patient's airway, and the adjuncts and procedures you utilized to secure the patient's airway. If you placed an endotracheal tube, be sure you verify placement by visualization and auscultation, and document the verification. Also indicate the size of ET tube or oral/nasal airway used.

PREHOSPITAL TRAUMA MECHANISM

This field is used to document the mechanism of injury for traumatic injury. Mark as many as necessary to document the mechanism(s) of your patient's trauma. For example, your patient was driving a vehicle when he was shot, then his vehicle crashed into the ditch and rolled over.



ANATOMICAL TRAUMA CRITERIA

This field is used to identify trauma center criteria. Mark as many as apply to your patient. Leave this field blank if none apply to your patient.

Anatomical Trauma Criteria

◯ Penetrating	◯ Flail chest
◯ Burns (>20%)	◯ Fracture
◯ Amputation	◯ Fracture Skull
◯ Paralysis	◯ Pelvis

Penetrating Includes gunshots, stabbing.

Burns (>20%) Patient has sustained burns over at least 20% of the body and/or burns to the face and/or airway.

Amputation Any portion of extremity.

Paralysis Patient has suffered paralysis of extremities secondary to traumatic event.

Flail Chest Patient is believed to have fractures two or more ribs in two or more places, thus damaging the integrity of the chest wall.

Fracture Fracture of any long bone.

Fracture Skull Fracture or suspected fracture of skull.

Pelvis Fracture or suspected fracture of pelvis.

POSSIBLE CONTRIBUTING FACTOR

Mark as many of the categories as applicable that could be considered to have potentially aggravated or contributed to the injury or illness.

Possible Contributing Factor

◯ Alcohol	◯ HAZMAT
◯ Substance	◯ Sports
◯ Extrication >15 min.	◯ Delay in EMS access
◯ Self-Infliction	◯ Delay in detection
◯ Patient abused	◯ Weather
◯ Equipment	◯ Med. Examiner Delay

GLASGOW COMA SCALE

Use this field to record responses of patients to certain stimuli using the Glasgow Coma Scale. Subsequent changes in the GCS should be documented in the narrative section. **This field MUST be completed if any ALS Treatment is marked.**

All three sections must be marked. Mark only one response in each of the three sections.

In general, the Glasgow Coma Scale can be used for determining the level of consciousness for any patient. It is critical that it be recorded during the evaluation of ALL trauma patients. Below are the guidelines for patient evaluation.

Glasgow Coma Scale		Motor
Eyes	Verbal	◯ 6 Obeys
◯ 4 Spontan.	◯ 5 Oriented	◯ 5 Localizes
◯ 3 To Speech	◯ 4 Confused	◯ 4 Withdraws
◯ 2 To Pain	◯ 3 Inapp.	◯ 3 Flexion
◯ 1 None	◯ 2 Garbled	◯ 2 Extension
Score_____	◯ 1 None	◯ 1 None

Eye Response

4. Eyes open spontaneously during initial assessment.
3. Eyes open to verbal commands or speech.
2. Eyes open only to painful stimulus.
1. Eyes do not open during initial evaluation period.

Verbal Response

5. Patient is oriented to person, place, and time; converses normally.
4. Patient converses, but is disoriented or confused to person, place, and time.
3. Patient is disoriented, speech clear, but inappropriate.
2. Speech is garbled, with words undeterminable. Includes grunting or moaning.
1. No verbal responses to any stimulation.

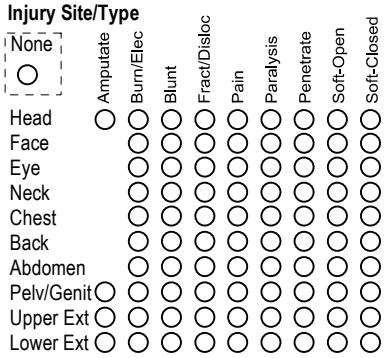
Motor Response

6. Obeys verbal commands by moving extremities or facial muscles (in case of C-Spine injuries)
5. Can localize a painful stimulus by moving an extremity to an injured area in a purposeful manner.
4. Withdraws an extremity from painful stimulus, but unable to localize or prevent recurring pain.
3. Abnormal flexor response to stimulus; decorticate (flexor) posturing.
2. Abnormal extensor response to stimulus; decerebrate (extensor) posturing.
1. No response, no motion to any painful stimulus.

INJURY SITE/TYPE

In this field, each individual injury can be broken down into type of injury and physiological location. **If TYPE OF CALL indicates a trauma-related call, this field must be marked.** More than one column or row can be used since the matrix is set up to categorize multiple injury patients as well as patients with only one particular complaint. Mark "None" for those patients in a trauma-related incident, but who have no evident injury or complaint.

Remember, during your assessment of a trauma patient, it is important to note that if the mechanism of injury is of sufficient force to cause open or closed injury to the face and/or head, there should be a high index of suspicion toward neck and back injury as well.



SAMPLE INJURY SITE/TYPE

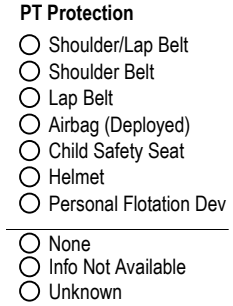
Head = Blunt, Soft-Open *Face= Blunt, Soft-Open*
Neck = Pain *Back = Pain*

PATIENT PROTECTION

This field refers to the type of safety devices or restraints that the patient was using at the time of injury. This information is critical and applies to all trauma-related calls where safety devices could or should have been in use, such as motor vehicle crashes, motorcycle, bicycle, boating, sports, recreational vehicle incidents. If your call involved an industrial incident and you observed safety devices in use or not, indicate this information in your narrative.

If you are unable to determine if the patient was using any type of safety device, mark "Unknown". If the patient was definitely not wearing a seat belt, helmet, etc., then mark "None Used." If safety devices were not available for the patient, mark "Not Available."

Note: If TYPE OF CALL is marked as "MVC", "Bicycle", "Motorcycle", or "ATV", then PT. PROTECTION must be marked.



PATIENT LOCATION

In this field, mark where the patient was originally located in/on the vehicle. If the patient's original location is unknown, mark "Unknown". If the patient's location was other than those listed, mark "Other."

PT Location
- ◯ Driver
- ◯ Pass. Front
- ◯ Pass. Left Rear
- ◯ Pass. Right Rear
- ◯ Truck Bed
- ◯ Other
- ◯ Unknown

RESCUE / EXTRICATION

Mark this field it the patient needed to be extricated with rescue equipment; Jaws of Life, air bags, ropes and litters, boats, or other rescue equipment. Indicate the total number of minutes required rescuing or extricating the patient from entrapment.

Rescue/ Extrication
- ◯ Yes
- ◯ No

Total Extrication Time

PUPILS

Record the responsiveness of the patient's pupils, both left and right, in the correct column. Mark **Normal**, if appropriate. In general, a **Constricted** pupil is abnormally small, whereas a **Dilated** pupil is abnormally large.

The term **Non-Reactive**, if appropriate, must be used in combination with Normal, Constricted, or Dilated. If a pupil is non-reactive, then you must also mark one of the other three bubbles. Remember that individual pupils react differently and to mark them appropriately.

Pupils

	Left	Right
Normal	◯	◯
Constricted	◯	◯
Dilated	◯	◯
Non-Reactive	◯	◯

Skin
- ◯ Warm ◯ Cyanotic
- ◯ Cool ◯ Diaphoretic
- ◯ Dry ◯ Pale
- ◯ Moist ◯ Pink

SKIN

This field is to document the initial condition of the patient's skin. Mark as many as are appropriate without contradiction.

PEDIATRIC TRAUMA SCORE

If the patient is between the ages of newborn and fourteen years of age, complete this field, regardless of the TYPE OF CALL.

Pediatric Trauma Score

Weight	Airway
◯ >20 kg (+2)	◯ Patent (+2)
◯ 10-20 kg (+1)	◯ Maintainable (+1)
◯ <10 kg (-1)	◯ Unmaintainable (-1)
CNS	BP
◯ Awake (+2)	◯ >90 (+2)
◯ Obtunded (+1)	◯ 90-50 (+1)
◯ Comatose (-1)	◯ <50 (-1)
Wounds	Skeletal
◯ None (+2)	◯ None (+2)
◯ Minor (+1)	◯ Closed Fx (+1)
◯ Major (-1)	◯ Open/Multi (-1)

Pediatric Weight

Estimate the patient's weight, in kilograms. Remember: 1 kg = 2.2 lbs.

❍ >20kg (+2) ❍ 10-20kg (+1) ❍ <10kg (-1)

Airway

Document the patient's airway status prior to your intervention.

❍ Patent (+2) ❍ Maintainable (+1) ❍ Unmaintainable (-1)

CNS

Document the patient's general level of consciousness.

❍ Awake (+2) ❍ Obtunded (+1) ❍ Comatose (-1)

BP

Document the patient's systolic blood pressure.

❍ >90 (+2) ❍ 90-50 (+1) ❍ <50 (-1)

Wounds

Document the total severity of wounds.

❍ None (+2) ❍ Minor (+1) ❍ Major (-1)

Skeletal

Document the total severity of skeletal fractures/dislocations.

❍ None (+2) ❍ Closed Fx (+1) ❍ Open/Multiple (-1)

REFUSAL OF CARE/TRANSPORT

Great care must always be used when accepting a patient's refusal to be assessed, treated, or transported. Remember that all patients have the right to refuse treatment and transportation. Follow your agency's protocol or policy in evaluating patients, accepting and documenting refusal. It is always best to obtain the signature of a witness to refusal, especially when the patient refuses to sign your refusal form.

This is to certify that I am refusing treatment/transport. I have been informed of the risk(s) involved, and hereby release the ambulance service, its attendants, and its affiliates, from all responsibility which may result from this action.	Patient Signature	Date/Time

DOUBLE – CHECKING YOUR REPORT FORM

RETURNED FORMS

In an effort to compile the most accurate base of Oklahoma emergency medical services data, a special computer system has been installed, and all new software has been written, to scan and analyze the forms you send in. The computer is programmed to check for certain combinations of marks on the form that represents illogical or unrealistic conditions in the field. If a form is marked incorrectly, the data from that form is kept out of the database and the form must be sent back to you for revision or correction.

As indicated previously, this new software will also scan the narrative section of your report. It is designed to "read" most forms of handwriting. However, to ensure the accuracy of the final data product, it is important that you attempt to print your narrative report. If the computer is unable to decipher illegible handwriting, the report will be returned to be rewritten in a more legible manner.

Returning forms for correction creates extra work for everyone. So be certain to check your report form against the error conditions in this section first before you send it to the state EMS office.

SECTIONS OF THE FORM
THAT MUST ALWAYS BE MARKED

- **INCIDENT NUMBER**
- **DATE**
- **CALL RECEIVED TIME**
- **ENROUTE TIME**
- **RESPONSE MODE**
- **RESPONSE OUTCOME**
- **TYPE OF CALL**
- **CALLED BY**
- **CREW MEMBER #1**

No matter what the nature of the call (even if it was cancelled); any form sent in must have these fields completed.

DEPART SCENE

This time must be filled in if its "companion", Arrive Scene, was marked.

RESPONSE MODE

The TO SCENE section of this field must be filled in. MARK ONLY ONE.

If the DEPART SCENE time field is marked, then the FROM SCENE section of this field must be filled in. MARK ONLY ONE.

INCIDENT LOCATION

This field must be marked if the ARRIVE SCENE field is marked. Use your best judgement. MARK ONLY ONE.

TYPE OF CALL

This field must be marked.

ASSISTANCE

Mark all that are appropriate in this section. Make sure that the aid rendered was PRIOR to your vehicle's arrival. **MARK AT LEAST ONE; MAY HAVE MUTLIPE MARKS.**

AGE

If a patient was contacted or treated at all, this field must be complete. If you are uncertain of the patient's age, and cannot obtain the exact information, use your best approximation, and mark APPROX.

INJURY SITE / TYPE

If TYPE OF CALL indicates a trauma – related call, this section must be marked with AT LEAST ONE MARK, OR MULTIPLE MARKS.

ANATOMICAL TRAUMA CRITERIA

To be filled in if INJURY SITE /TYPE is marked. If ANATOMICAL TRAUMA CRITERIA does not apply to INJURY SITE /TYPE, simply leave blank.

PATIENT PROTECTION

Must be completed if TYPE OF CALL is marked MVC, MOTORCYCLE, ATV, BICYCLE, or other trauma related calls where safety devices could or should have been in use. If patient did not use safety devices, mark NONE. If no safety devices were available, mark NOT AVAILABLE. If you are unsure and cannot determine whether safety devices were used, mark UNKNOWN.

PATIENT LOCATION

Must be completed when PATIENT PROTECTION is marked. If call is not vehicle-related, then leave this blank. If original location of the patient is not known, or different from those listed, select OTHER or UNKNOWN.

GLASGOW COMA SCALE

If BLS TREATMENT or ALS TREATMENT is marked, then this field must be filled in with ONE MARK PER COLUMN.

VITAL SIGNS

If you did not contact or treat a patient, that is if your RESPONSE OUTCOME is marked, "Cancelled", "Refused", "False Call", "POV", "No Pt Found", or "Standby", there is no need to list vital signs.

If you contacted or transported a patient, you should document at least one set of vital signs in the VITAL SIGNS – TREATMENT /RESPONSE section. If you were unable to take the vital signs of a patient, indicate the reason you were unable to take vital signs.

If BLS TREATMENT is marked as “CPR”, this section must be completed (even if all zeros) along with the time of first assessment, and there must be a mark in “PULSE RESTORED?” in the Cardiac Arrest information field.

IV TYPE / RATE

If ALS TREATMENT is marked as IV-Central, IV-Ext, Jugular, IV-Intraosseous, or IV-Peripheral, then the IV section must be marked.

MEDICATION TREATMENT CATEGORY

At least one medication treatment category, even if only one medication is administrated, should be marked if the ALS TREATMENT section is marked as “DRUG ADMIN.” Some medications are common to multiple categories. Mark only the appropriate treatment category for which that drug was administrated.

EKG

The EKG section of the form must be marked if any of the following are marked in ALS TREATMENT:

- Cardiac Monitor
- Manual Defib.
- Cardioversion

MEDICAL CONTROL

If any marks are made in the ALS section of the form, this field must be filled in with one mark.

CPR

The CPR field must be filled in if BLS TREATMENT is marked “CPR” or if the SUSPECTED MEDICAL ILLNESS was marked “Cardiac Arrest”. The “Pulse Restored?” MUST ALSO HAVE ONE MARK.

CREW MEMBER 1 AND CREW MEMBER 2

CM1 must be filled in completely for all calls. If any procedures in the BLS TREATMENT or ALS TREATMENT sections are marked CM2, then the CrewMember 2 section must be filled in appropriately. Be certain to mark <u>both</u> the Crew member’s type (B, I, AC, P, HP, Oth, 1st R., Stdnt) <u>and</u> their appropriate license or certification number.